MAXIMUS Federal Services

| Case Number: | CM15-0084103 | | |
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| Date Assigned: | 05/06/2015 | Date of Injury: | 09/30/2000 |
| Decision Date: | 06/09/2015 | UR Denial Date: | 04/02/2015 |
| Priority: | Standard | Application Received: | 05/01/2015 |

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

## CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 65 year old male, who sustained an industrial injury on 9/30/00. The injured worker has complaints of right shoulder pain and spasms in the back. The diagnoses have included myofascial pain syndrome; repetitive strain injury and knee pain. Treatment to date has included Medial branch block injection done on 2/20/15 with prior to procedure pain level was 8/10 and after the pain level was 1/10; naprosyn; omeprazole; flexeril neurontin and methoderm gel. The request was for gabapentin 600 mg #100 with 3 refills; trigger point injection x4 to right trapezius 40 mg 5cc 2% lidocaine and bilateral L3 L4 L5 S1 medial branch rhizotomy.

## IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Gabapentin 600 mg #100 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

**Decision rationale:** According to MTUS guidelines, "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." There was no documentation that the patient is suffering from neuropathic pain including diabetic neuropathic pain or post-herpetic neuralgia condition. There is no documentation of efficacy and safety from previous use of Gabapentin. Therefore, the prescription of Gabapentin 600mg #100 with 3 refills is not medically necessary.

**Trigger point injection x4 to right trapezius 40 mg 5cc 2% lidocaine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections, page(s) Page(s): 122.

**Decision rationale:** According to MTUS guidelines, trigger point injection is "recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Not recommended for radicular pain. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004)" "Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended." There is no clear evidence of myofacial pain and trigger points over the trapezius muscle. There is no documentation of twitch response and referral pain. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for Trigger point injection x4 to right trapezius 40 mg 5cc 2% lidocaine is not medically necessary.

**Bilateral L3 L4 L5 S1 medial branch rhizotomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Facet joint intra-articular injections (therapeutic blocks)
(http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections).

**Decision rationale:** According MTUS guidelines, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." According to ODG guidelines regarding facets injections, "Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra- articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial." Furthermore and according to ODG guidelines, "Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection."
According to MTUS guidelines, "there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain.
Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks." The ODG guidelines did not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain. The guidelines do not allow facet injection for more than 2 joint levels. In addition, there is no clear evidence or documentation that lumbar facets are main pain generator. Therefore, the request for Bilateral L3 L4 L5 S1 medial branch rhizotomy is not medically necessary.